BAY REGION ORTHOPEDIC SURGERY

Date: ______________________

Name: ____ Date of Birth: ________________

Family Doctor: ____________________________ Referred by: ____________________________

Height: _________ Weight: _________ Right Handed _____ Left Handed _____ Age:* _________

Chief Complaint: What are you being seen for today? ____

Is this a result of:

Injury? ☐ Yes ☐ No

Car Accident? ☐ Yes ☐ No

Work Accident? ☐ Yes ☐ No

Date of Onset or Date of Injury: ______________(mm/dd/yyyy)

Other Accident? ____

Other: ____

Have you had any previous problems with the same area? ____________________________

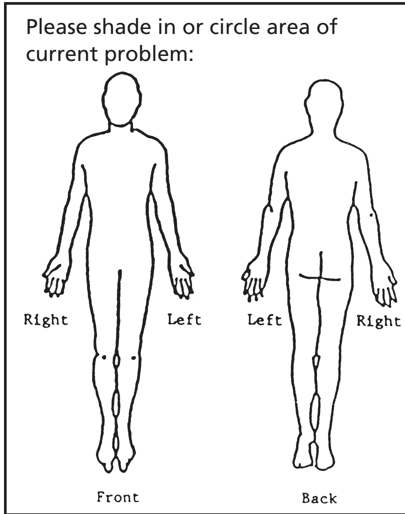
Are you on: full duty _____ light duty _____ off work _____

What started your problem or pain?* ____

Treatments have included:

- ☐ No medications, therapy, injections braces or casts
- ☐ Physical therapy or exercise
- ☐ Anti-inflammatory meds
- ☐ Massage or ultrasound
- ☐ Narcotic meds
- ☐ Traction
- ☐ Braces
- ☐ Manipulation/ chiropractic
- ☐ Cortisone injections, how many?
- ☐ Tens Unit
- ☐ Cast
- ☐ Name of last medication taken for this problem: ______________

Please shade in or circle area of current problem:



Pain Symptoms: Please Check Current Symptoms

- ☐ Pain
- ☐ Aching
- ☐ Activity Related
- ☐ Burning
- ☐ Dull
- ☐ Night Time
- ☐ Post Activity
- ☐ Radiating
- ☐ Sharp
- ☐ Spasm
- ☐ Throbbing
- ☐ Tingling/Numbness
- ☐ Weakness
- ☐ Walking Problems
- ☐ Popping Sensation
- ☐ Giving Way
- ☐ Grinding
- ☐ Instability
- ☐ Limited Range of Motion
- ☐ Soreness
- ☐ Stiffness
- ☐ Swelling
- ☐ Tenderness
- ☐ Inability to Perform Sport

Previous doctors seen for this problem: ☐ None

Doctor	Speciality	Date	Treatment

Tests done to evaluate your problem: ☐ None

Please list date of studies, results, and where study done if known. ☐ None

☐ Plain X-rays __________ ☐ EMG/NCV __________ ☐ MRI/CT __________ ☐ Bone scan __________

☐ Other: ____

☐ Other tests ____

Medications (Please list both prescription and non-prescription, including dose and frequency)

____

____

Allergies (Please list medications to which you are allergic or cannot take; please list nature of reaction) ☐ None

____

____

Surgical History: (Please list previous surgeries) ☐ None

Operation	Surgeon	Date

REVIEW OF SYMPTOMS—DO YOU HAVE:

1. **CARDIOVASCULAR**	**YES**	**PAST**	**NO**	**IF YES, GIVE DETAILS**	**PHYSICIAN'S NOTES**
PAINFUL BREATHING	☐	☐	☐		
CHEST PAIN OR PRESSURE	☐	☐	☐		
DIFFICULTY BREATHING ON EXERTION	☐	☐	☐		
SWELLING OF LEGS	☐	☐	☐		
RAPID OR IRREGULAR HEARTBEAT	☐	☐	☐		
2. **RESPIRATORY**					
WHEEZING	☐	☐	☐		
SPITTING UP BLOOD	☐	☐	☐		
SHORTNESS OF BREATH	☐	☐	☐		
CHRONIC COUGH	☐	☐	☐		
3. **GASTROINTESTINAL**					
FREQUENT DIARRHEA	☐	☐	☐		
BLOODY STOOL	☐	☐	☐		
NAUSEA/VOMITING/INDIGESTION	☐	☐	☐		
CONSTIPATION	☐	☐	☐		
INVOLUNTARY LOSS OF GAS OR STOOL	☐	☐	☐		
4. **GENITOURINARY**					
BLOOD IN URINE	☐	☐	☐		
PAIN WITH URINATION	☐	☐	☐		
STRONG URGENCY TO URINATE	☐	☐	☐		
FREQUENT URINATION	☐	☐	☐		
INCOMPLETE EMPTYING	☐	☐	☐		
5. **MUSCULOSKELETAL**					
MUSCLE OR JOINT PAIN	☐	☐	☐		
6. **SKIN**					
RASH	☐	☐	☐		
SORES	☐	☐	☐		
DRY SKIN	☐	☐	☐		
MOLES	☐	☐	☐		
7. **NEUROLOGIC**					
DIZZINESS	☐	☐	☐		
NUMBNESS	☐	☐	☐		
TROUBLE WALKING	☐	☐	☐		
8. **HEMATOLOGIC/LYMPHATIC**					
FREQUENT BRUISES	☐	☐	☐		
CUTS DO NOT STOP BLEEDING	☐	☐	☐		

Please give details to those answered Yes:____

____

____

FAMILY HISTORY

Please check any problems that run in your family.

- HEART ATTACK ☐
- STROKE ☐
- BLEEDING DISORDER ☐
- CANCER—IF YES WHAT TYPE ☐ ______________________ ______________________
- HEART TROUBLE ☐
- ANEURYSM ☐
- ARTHRITIS ☐
- ASTHMA ☐
- GOUT ☐
- ALCOHOLISM ☐
- DIABETES ☐
- KIDNEY TROUBLE/STONES ☐
- MENTAL ILLNESS ☐
- OTHER: ☐ ______________________ ______________________

SOCIAL HISTORY

WORK STATUS:

- WORKING ☐
- RETIRED ☐
- UNEMPLOYED ☐
- HOMEMAKER ☐
- DISABLED ☐

SPORTS YOU CURRENTLY PLAY

____

____

DO YOU EXERCISE:

- DAILY ☐
- WEEKLY ☐
- MONTHLY ☐
- RARELY ☐
- NEVER ☐

WHAT TYPE OF EXERCISE:

____

____

Occupation (current or most recent): ______________________

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Tobacco Use: ☐ Never Smoked ☐ Cigar ☐ Chew ☐ Piped ☐ Cigarettes

Packs Per Day For: ____________ Years ____________

Quit Smoking (Years Ago): ____________ After Smoking (Packs Per Day/For Years): ____________

Alcohol: ☐ Alcoholic ☐ Recovering Alcoholic ☐ Never

☐ Rare ☐ Social (How Much?) ____________

Environmental Issues:

How do you prefer to learn?: ☐ Demonstration ☐ Read Instructions ☐ Picture Directions

☐ Cultural Barriers______________________

☐ Interpretator needed, Language______________________

We know that violence and/or sexual abuse is a problem for many people, so we routinely screen all patients for abuse or violence in their lives. Is this a problem for you in any way? ☐ Yes ☐ No

PLEASE COMPLETE THE FOLLOWING FOR CHILDREN UNDER 10 YEARS OF AGE:

Birth Weight: ____________

Order of birth (1st born, 2nd born, etc.): ______________________

Events of pregnancy: ____ Full Term ____ C-Section ____ Premature Birth

____ Late Delivery ____ Vaginal Delivery

SIGNATURE OF PATIENT:	DATE:
PHYSICIAN SIGNATURE:	DATE REVIEWED: / /
PHYSICIAN SIGNATURE:	DATE REVIEWED: / /
PHYSICIAN SIGNATURE:	DATE REVIEWED: / /